CT Family Foot Care
and
Surgery, LLC

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CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Patient Information

Name _____ Birthdate _____ Marital Status ____

Home Address _____ Home Phone _____

City _____ State ____ Zip _____ Cell Phone _____

Employed by _____ Work Phone _____

Occupation _____

Patient Social Security # _____

Primary Care Physician _____ Date of Last Exam _____

Referred by _____

Insurance Information

Primary Medical Insurance _____ ID # _____

Secondary Insurance (if any) _____ ID # _____

Insured Information (family member that insurance is issued to)

Name of subscriber _____ Relationship to Patient _____

Subscriber's address _____

_____

Subscriber's Social Security # _____ Date of Birth _____

What is the reason for your visit today? _____
_____ Result of accident or work injury? _____
How long has this bothered you? _____What is your level of pain? _____/10 (1=mild, 10=severe)

Payment is expected at time of visit. In the event of default, the patient is responsible for reasonable collection and/or attorney's fees. I will be held financially responsible for any rejected claims due to insufficient referrals or incorrect insurance information.
I have read and understand the above.

Signature _____ Date _____

MEDICAL HISTORY

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

Acid Reflux/GERD	□ Yes	□ No	Circulatory Problems	□ Yes	□ No	Neuropathy	□ Yes	□ No
AIDS/HIV	□ Yes	□ No	Depression	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Alcohol Dependency	□ Yes	□ No	Diabetes	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Anxiety Disorder	□ Yes	□ No	Gout	□ Yes	□ No	Stents	□ Yes	□ No
Arthritis	□ Yes	□ No	Heart Disease	□ Yes	□ No	Thyroid Disorder	□ Yes	□ No
Asthma	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Ulcers (stomach)	□ Yes	□ No
Back Problems	□ Yes	□ No	Hepatitis/Jaundice	□ Yes	□ No	Ulcers (feet)	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Venereal Dis.	□ Yes	□ No
Blood Clots	□ Yes	□ No	Joint Replacement	□ Yes	□ No	Other _____		
Cancer _____	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Other _____		
Chemical Dependency	□ Yes	□ No	Liver Disease	□ Yes	□ No	Other		
Are you pregnant?	□ Yes	□ No	**Are you nursing?**	□ Yes	□ No			

Surgeries you have had _____

_____ None □

Social History

Smoking Status: □ Current Some Day Smoker □ Current Every Day Smoker _____ packs/day, for _____ years

□ Former Smoker _____ packs/day, for _____ years. □ Never smoked □ Decline to answer

Do you exercise regularly? □ No □ Yes, I do the following exercise: _____

Family History (please indicate family member)

□ Diabetes _____ □ Arthritis _____ □ Heart Disease _____

□ Cancer _____ □ Circulatory problems _____ □ Bleeding disorders _____

Symptoms (please check the box if you currently have any of these symptoms or check "NONE")		
General	□ Fever □ Chills □ Weight gain □ Weight loss □ Hearing difficulty	□ N**ONE**
Cardiovascular	□ Leg pain when walking □ Chest pain/pressure □ Leg swelling □ Fainting □ Cold hands/feet □ Palpitations	□ **NONE**
Genitourinary	□ Blood in urine □ Excessive urination □ Incontinence □ Pain while urinating	□ **NONE**
Gastrointestinal	□ Abdominal pain □ Nausea □ Vomiting □ Reflux/Heartburn □ Blood in stool □ Diarrhea □ Trouble swallowing □ Decreased appetite □ Increased appetite	□ **NONE**
Skin	□ Athletes foot □ Nail abnormalities □ Itchiness □ Dry skin □ Excessive sweating	□ **NONE**
Hematologic	□ Lower leg ulcers □ Anemia □ Blood thinners □ Clotting disorder	□ **NONE**
Neurologic	□ Tingling □ Numbness □ Weakness □ Tremors □ Paralysis □ Seizures □Headaches	□ **NONE**
Musculoskeletal	□ Back pain □ Joint swelling □ Joint pain □ Muscle pain □ Joint stiffness □ Arthritis □ Joint instability □ Neck pain □ Muscle weakness	□ **NONE**
Respiratory	□ Shortness of breath □ Wheezing □ COPD □ Coughing □ Snoring □ Emphysema	□ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above

Patient Signature: _____Date: _____

CURRENT MEDICATIONS

□ I take the following medications (please include prescriptions, over-the-counter medications, and vitamins):

Name	Dosage	Name	Dosage
		Use the back of this form if more room is needed	

□ I take no medications

Pharmacy Name: _____ **Pharmacy Phone #: _____**
Pharmacy Address: _____ City, State, Zip**: _____**

ALLERGIES □ No known drug allergies □ Seasonal/Hayfever

□ Adhesive, □ Aspirin, □ Codeine, □ Iodine, □ Local Anesthetics, □ Penicillin, □ Seafood, □ Sulfa
Other _____

PLEASE PROVIDE US WITH YOUR MOST RECENT:

Height: _____ Weight: _____ Shoe size: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? □ Yes □ No

Can we send mail to the address on file? □ Yes □ No

Can we call the phone number of file? □ Yes □ No

Can we leave a voicemail message on your machine/phone? □ Yes □ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? □ Yes □ No

If yes, please provide your email address: _____

Who can we leave message with? □ Wife □ Husband □ Daughter □ Son □ Partner □ Friend □ Other
Name(s): _____

Race:	**Ethnicity:**
□ White □ American Indian □ Black/African □ Native Hawaiian □ Asian □ Decline to specify **Preferred Language:_____**	□ Hispanic/Latino □ Not Hispanic/Latino □ Decline to specify

PLEASE READ AND SIGN: The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. *(Release of Information):* I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received or had the opportunity to read my HIPAA Privacy Practices Notice. *(Medication History):* I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____